Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
E-Mail: web@drl.state.wi.us
Phone #: (608) 266-2112
Website: http://www.drl.state.wi.us

HOSPITAL VERIFICATION - PRIVILEGES, EMPLOYMENT OR APPOINTMENT

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL/FACILITY: _____

HOSPITAL/FACILITY ADDRESS: _____

HOSPITAL/FACILITY TELEPHONE: _____

1. What position did this physician hold at your facility? _____

2. What were this physician's dates of employment or staff privileges at your facility? _____

		YES	NO
3.	Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
4.	Was this physician granted a leave of absence while employed at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
5.	Did this individual have a record of unexcused absences during his/her attendance at this facility?	☐	☐
6.	Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7.	Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐
9.	Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐

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		YES	NO
10.	Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Was this physician involuntarily removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician subject to non-routine quality assessment review? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Was this physician the subject of a negative review by a quality assurance or departmental committee? If yes, please attach explanation on a separate sheet.	☐	☐

_____ _____

Name and Title of Certifying Official Date

SEAL OF HOSPITAL
(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935